(i) Labor. The percentage change for labor costs is based on the projected average hourly wage of North Carolina service workers. Salaries for all personnel shall be limited to levels of comparable positions in state owned facilities or levels specified by the Division of Medical Assistance.

(ii) Nonlabor. The percentage change for nonlabor costs is based on the projected annual change in the implicit price deflator for the Gross National Product as provided by the North Carolina Office of State Budget and Management.

(iii) Fixed. No price level adjustment shall be made for this category.

(D) The weights computed in Part (k)(1)(B) of this Section shall be multiplied by the rates computed in Part (k)(1)(C) of this Section. These weighted rates shall be added to obtain the composite inflation rate to be applied to both the direct and indirect rates.

(2) If necessary, the Division of Medical Assistance shall adjust the annual inflation factor in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations

(l) Effective July 1, 1995, any rate reductions resulting from the State Plan **Amendment 95-03** shall be implemented based on the following deferral methodology:

(1) Rates shall be reduced for the excess of current rates over base year costs plus inflation.

(2) Rates shall be reduced a maximum of 50 percent of the fiscal 1996 inflation rate for the excess of actual costs over applicable cost limits. This reduction shall result in the facility receiving at a minimum 50 percent of the 1996 inflation rate. Any excess reduction shall be carried forward to future years.

(3) Total reduction in future years related to the excess reduction carried forward from Subparagraph (l)(2) of this Section, shall not exceed the annual rate of inflation. This reduction shall result in the facility receiving at minimum the rate established in Paragraph (1)(2) of this Section. Any excess reduction shall be carried forward to future years, until the established rate equals that generated by Paragraphs (f),(g), and (k) of this Section.

(4) Rates calculated based on Subparagraphs (l)(2) and (3) of this Section shall be cost settled based on the provisions of Subparagraph (j)(1) of this Section until the fiscal year that the facility receives full price level increase under Paragraph (k) of this Section.

(A) A provider may make an irrevocable election to cost settle under the provisions of Paragraphs (h) and (i) of this Section during the deferral period.

(B) Once the rates calculated based on Subparagraphs (1)(2) and (3) of this Section reach the fiscal year that the facility receives the full price level increase under Paragraph (k), then said fiscal year's rates shall be cost settled based on Paragraphs (h) and (i) of this Section.

(C) Chain providers are allowed to file combined cost reports, for cost settlement purposes, for facilities that use the same cost settlement methodology and have the same uniform rate.

(D) A provider may request from the Division of Medical Assistance permission to continue cost settlement under Subparagraph (j)(1) of this Section after the deferral period expires. Said request shall be made each year, 30 days prior to the

cost report due date.

(m) The initial rate for facilities that have been awarded a Certificate of Need is established at the lower of the fair and reasonable costs in the provider's budget, as determined by the Division of Medical Assistance, or the projected costs in the provider's Certificate of Need application, adjusted from the projected opening date in the Certificate of Need application to the current rate period in which the facility is certified based on the price level change methodology set forth in Paragraph (k) of this Section, or the rate currently paid to the owning provider, if the provider currently has an approved chain rate for facilities in the related facility category. The rate may be rebased to the actual cost incurred in the first full year of normal operations in the year an audit of the first year of normal operation is completed.

(1) In the event of a change in ownership, the new owner receives no more than the rate of payment assigned to the previous owner.

(2) Except in cases wherein the provider has failed to file supporting information as requested by the Division of Medical Assistance, initial rates shall be granted to new enrolled facilities no later than 60 days from the provider's filing of properly prepared budgets and supporting information.

(3) The initial rate for a new facility shall be applicable to all dates of service commencing with the date the facility is certified by the Medicaid Program.

(4) The initial rate for a new facility shall not be entered into the Medicaid payment system until the facility is properly enrolled in the Medicaid program and a Medicaid identification number has been assigned to the facility by the Division of Medical Assistance.

(n) A provider with more than one facility may be allowed to recover costs through a combined uniform rate for all facilities.

(1) Combined uniform rates for chain providers shall be approved upon written request from the provider and after review by the Division of Medical Assistance.

(2) In determining a combined uniform rate for a chain provider, the weighted average chain rate is calculated as follows:

(A) For each facility, multiply the facility-specific rate, calculated in accordance with paragraphs (f) and (g) and all other provisions of this plan, by facility-specific number of beds.

(B) Add products of calculations in Item A.

(C) Divide sum of Item B by total number of beds of all facilities included in item A. This is the weighted average chain rate.

(3) A chain provider with facility(s) that fall under Paragraphs (h) and (i) of this section and with facility(s) that fall under Subparagraph (1)(4) of this Section may elect to include **all** the facilities in a combined cost report and elect to cost settle under either Paragraphs (h) and (i) or Subparagraph (1)(4). The cost settlement selection shall be made each year, 30 days prior to the cost report due date.

(o) Each out-of-state provider shall be reimbursed at the lower of the applicable North Carolina rate,.

as established by this plan for in-state facilities, or the provider's per diem rate as established by the sate in which the provider is located. An out-of-state provider is defined as a provider that is enrolled in the Medicaid program of another state and provides ICF-MR services to a North Carolina Medicaid client in a facility located in the state of enrollment. Rates for out-of-state providers are not subject to cost settlement.

(p) Under no circumstances shall the Medicaid per diem rate exceed the private pay rate of a facility.

(q) Should the Division of Medical Assistance be unable to establish a rate for a facility, based on this Section and the applicable facts known, the Division of Medical Assistance may approve an interim rate.

(1) The interim rate shall not exceed the rate cap established under this Section for the applicable facility group.

(2) The interim rate shall be replaced by a permanent rate, effective retroactive to the commencement of the interim rate, by the Division of Medical Assistance, upon the determination of said rate based on this Section and the applicable facts.

(3) The provide shall repay to the Division of Medical Assistance any overpayment resulting from the interim rate exceeding the subsequent permanent rate.

(r) In addition to the prospective per diem rate developed under this Section, effective July 1, 1992, an interim payment add on shall be applied to the total rate to cover the estimated cost required under Title 29, Part 1910, Subpart 2, Section 1910.1030 of the Code of Federal Regulations. **The interim payment add-on is based on a cost model developed from an analysis of the incremental costs associated with this program. Total incremental costs from the cost model divided by total bed days yields the interim per diem add-on.** The interim rate shall be subject to final settlement reconciliation with reasonable cost to meet the requirements of Section 1910.1030. The final settlement reconciliation shall be effectuated during the annual cost report settlement process. An interim rate add-on to the prospective rate shall be allowed, subject to final settlement reconciliation, in subsequent rate periods until cost history is available to include the cost of meeting the requirements of Section 1910.1030 in the prospective rate. This interim add-on shall be removed, upon 10 days written notice to providers, should it be determined by appropriate authorities that the requirements under Title 29, Part 1910, Subpart 2, Section 1910.1030 of the Code of Federal Regulations do not apply to ICF-MR facilities.

(s) All rates, except those noted otherwise in this Section, approved under this Section are considered to be permanent.

(t) In the event that the rate for a facility cannot be developed so that it shall be effective on the first day of the rate period, due to the provider not submitting the required reports by the due date, the average rate for facilities in the same facility group, or the facility's current rate, whichever is lower, shall be in effect until such time as the Division of Medical Assistance can develop a new rate.

(u) When the Division of Medical Assistance develops a new rate for a facility for which a rate was paid in accordance with Paragraph (t) of this Section, the rate developed shall be effective on the first day of the second month following the receipt by the Division of Medical Assistance of the required reports. The Division of Medical Assistance may, upon its own motion or upon application and just cause shown by the provider, within 60 days subsequent to submission of the delinquent report, make the rate retroactive to the beginning of the rate period in question. Any overpayment to the provider resulting from this temporary rate being greater than final approved prospective rate for the facility shall be repaid to the Medicaid Program.

(v) ICF-MR facilities meeting the requirements of the North Carolina Division of Facility Services as a facility affiliated with one or more of the four medical schools in the state and providing services on a statewide basis to children with various developmental disabilities who are in need of long-term high acuity nursing care, dependent upon high technology machines (i.e. ventilators and other supportive breathing apparatus), monitors, and feeding techniques shall have a prospective payment rate that approximates cost of care. The payment rate may be reviewed periodically, no more than quarterly, to assure proper payment. **The prospective payment rate is based on the Division of Medical Assistance's review of the facilities' budgets, cost reports, and other appropriate data, including budgeted costs and bed days. These facilities are paid an interim per diem which is calculated by dividing the facility's budgeted costs by the facility's budgeted bed days.** A cost settlement at the completion of the fiscal period year end is required. Payments in excess of cost are to be returned to the Division of Medical Assistance.

(A) Upon proper notice and review, the Division of Medical Assistance may establish a prospective rate for said facilities, subject to cost settlement procedures of paragraphs (h) and (i) of this Section.

(w) A special payment in addition to the prospective rate shall be made in the year that any provider changes from the cash basis to the accrual basis of accounting for vacation leave costs. The amount of this payment shall be determined in accordance with Title XVIII allowable cost principles and shall equal the Medicaid share of the vacation accrual that is charged in the year of the change including the cost of vacation leave earned for that year and all previous years less vacation leave used or expended over the same time period and vacation leave accrued prior to the date of certification. The payment shall be made as a lump sum payment that represents the total amount due for the entire fiscal year. An interim payment may be made based on an estimate of the cost of the vacation accrual. The payment shall be adjusted to actual cost after audit.

(x) The annual prospective rate, effective beginning each July 1, for facilities that commenced operations under the Medicaid Program subsequent to the base year used to establish rates, and therefore did not file a cost report for the base year, shall be based on the facility's initial rate, established in accordance with Paragraph (m) of this Section, and the applicable price level changes, in accordance with Paragraph (l) of this Section.

MEDICAL ASSISTANCE
State: North Carolina

PROSPECTIVE REIMBURSEMENT PLAN FOR ICF-MR FACILITIES
PAYMENT FOR SERVICES

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(y) Effective for fiscal years beginning on or after fiscal year 1998, installation cost of Fire Sprinkler Systems in an ICF-MR Facility shall be reimbursed in the following manner.

(1) Upon receipt of the documentation listed in Parts (A) through (E) of this Subparagraph, the Division of Medical Assistance shall reimburse directly to the provider ninety percent of the verified cost.
   (A) All related invoices.
   (B) Verification from the Division of Facility Services that the Sprinkler System is needed.
   (C) Statement from appropriate authorities that the Sprinkler System has been installed.
   (D) Three bids to install the system.
   (E) Prior approval from the Division of Medical Assistance for any installation projected to cost more than $25,000.

(2) The unreimbursed installation cost shall be reimbursed after audit through the annual Cost Settlement Process. This portion shall be offset by profits, after taking into consideration any indirect profits and direct losses. Any overpayments determined after audit shall be returned to the program by the provider through the annual cost settlement process.

(3) The installation of the Sprinkler System is subject to Prudent Buyer Standards contained in the HCFA-15.

(4) The Sprinkler System's installation costs shall be properly recorded on the provider's ICF-MR Cost Report.

Allowable Costs

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.0305 Allowable Costs

(a) To be considered allowable, costs shall not exceed fair and reasonable levels as determined by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, and shall be required to provide necessary client care under the Medicaid Program.

(1) The cost of goods or services sold to non-Medicaid clients shall be excluded in determining the allowable client related expenses reimbursable under the Medicaid program. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(2) Examples of sources of such income items include, but are not limited to:

(A) supplies and drugs sold by the facility for use by nonresidents,

(B) telephone and telegraph services for which a charge is made,

(C) discount on purchases,

(D) employee rental of living quarters,

(E) cafeterias,

(F) meals provided to staff or a client's guest for which there is a charge,

(G) lease of office and other space by concessionaires providing services not related to intermediate care facility services,

(H) interest income except for income earned on qualified pension funds and income from gifts or grants which are donor restricted.

(b) Except where specific Sections concerning allowability of costs are stated herein, the Division of Medical Assistance shall use as its major determining factor in deciding on the allowability of costs, the Medicare Provider Reimbursement Manual, published by the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). Where specific Sections stated herein or in HCFA-15 are silent concerning the allowability of costs, the Division of Medical Assistance shall determine allowability of costs based on a case specific review taking into consideration the reasonableness of said costs and their relationship to client care and generally accepted accounting principles, consistent with this State Plan.

(c) As determined by the Division of Medical Assistance, expenses or portion of expenses reported by an individual facility that are not reasonably related to the efficient and economical provision of care in accordance to the requirements of this Plan, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, because of either the nature or amount of the item, shall not be allowed.

(1) Reasonable compensation, as determined by Division of Medical Assistance, of individuals employed by a provider is an allowable cost, provided such employees are engaged in client related functions and that the compensation is reasonable in light of industry historical data. The historical data shall include, but not be limited to, salary levels for similar services in the same market in which the facility is located.

(2) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the Division of Medical Assistance. Payroll records shall indicate each employee's classification, hours worked, rate of pay, and the functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one cost center, the provider shall maintain periodic time studies in order to allocate salary and wage costs to the appropriate cost centers as determined by the Division of Medical Assistance. These periodic time studies shall be maintained in accordance with the Medicare Provider Reimbursement Manual.

(3) The Division of Medical Assistance shall not reimburse costs related to excess staff, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.

(4) Compensation for owners is allowable only for duties which the owner is qualified to render and that otherwise would require the employment of another individual in the provision of ICF-MR related services. Said compensation shall be limited to a reasonable amount, as determined by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, not to exceed that paid in the local market place for similar type duties. Compensation for owners is not allowable where the services are not related to the provision of ICF-MR related services.

(d) As determined by the Division of Medical Assistance, costs which are not properly related to client care or treatment, and which principally afford diversion, entertainment or amusement to owners, operators, or employees of the facility shall not be allowed.

(e) Costs for any interest expense related to funding expenses in excess of a fair and reasonable amount based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, or penalty imposed by governmental agencies or courts and the costs of insurance policies obtained solely to insure against such penalty, shall not be allowed.

(f) Costs of contributions or other payments to political parties, candidates or organizations shall not be allowed.

(g) As determined by the Division of Medical Assistance, only that portion of dues paid to any professional association which has been demonstrated to be reasonable in amount and attributable to Medicaid Program related expenditures other than for lobbying or political contributions shall be allowed. The burden of proof shall be on the provider to justify the inclusion of any professional association dues. Association budgets may be considered in determining said justification. At a minimum, the preponderance of evidence must show a benefit to the providers' operations from membership in the association.

(h) Any cost of the sale, purchase, alteration, construction, rehabilitation or renovation of a physical plant or interest in real property shall be considered allowable up to the amount approved by the Division of Medical Assistance. Cost is limited by the applicable provisions of paragraphs (i) and (1) of this Section. Cost is allowable only to the extent it is necessary for the provision of adequate client care under this Plan, as determined by the Department of Health and Human Resources.

Cost, and the associated financing, equal to or greater than ten thousand ($10,000) related to existing facilities or the construction of replacement facilities is subject to prior Division of Medical Assistance approval. Providers shall not incur said costs in a piece meal fashion in order to avoid the ten thousand ($10,000) limit. Failure to acquire prior approval shall result in the disallowance of said cost from Medicaid reimbursement, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(1) The provider shall file the necessary documentation to support the justification for the proposed expenditure and related financing with the Division of Medical Assistance no later than ninety (90) days prior to the proposed transaction's commencement date.

(2) The Division of Medical Assistance shall render a decision in writing to the provider on the propriety of the proposed transaction no later than thirty (30) days prior to the proposed transaction's commencement date.

(3) The time requirements of Subparagraphs (h)(1) and (2) of this Section shall be altered , by the Division of Medical Assistance with just cause shown that failure to make timely filing was caused by reasons beyond the control of the provider.

(4) For any transaction resulting in a change of ownership, the valuation of the asset shall be limited to the lesser of the allowable acquisition cost of the assets to the first owner of record who has received Medicaid payment for said asset, less any accumulated depreciation, plus any allowable improvements, or the acquisition cost of the asset to the new owner. Payment of rent by the Medicaid enrolled provider to the lessor of a facility shall constitute Medicaid payments under this Plan.

(5) Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under Medicaid, shall not be allowable for reimbursement.

(6) An exception may be applied by the Division of Medical Assistance to the requirements of either Subparagraph (h)(4) or (5) of this Section, if it can be proven that the change in ownership shall result in increasing the level of care provided to the facility's clients up to the level required by the Division of Facility Services.

(A) In order to meet this exception, it shall be proven that the previous facility owner was not providing, and was incapable of providing, adequate client service, as determined by the Department of Human Resources.

(B) The burden of proof in supporting this exception is on the provider. The provider shall request, in writing, consideration of this exception from the Division of Medical Assistance.

(C) Consideration of this exception may result in the Division of Medical Assistance allowing some or all of the costs in Subparagraph (h)(5) for Medicaid reimbursement.

(D) Consideration of this exception may result in the Division of Medical Assistance allowing a substitute valuation as determined on a case by case basis and based on the preponderance of evidence for the transferred property under Subparagraph (h)(4) that is greater than the limit noted, but in no instance greater than the acquisition cost of the assets to the new owner.

(i) A facility's annual rental payments for real property may be considered an allowable cost subject to the following conditions and the limits included in Paragraph (i)(1) of this Section:

(1) The lease is reviewed by and acceptable to the Division of Medical Assistance.

(A) The lease shall not be acceptable if the associated asset(s) are not needed for client care as determined by the Division of Medical Assistance.

(B) The lease shall not be acceptable if alternate means of financing is deemed available and more economical. In making this determination all aspects of the economic impact of the lease shall be examined including length of lease, the cost of the asset to the owner, and the incremental rate of return provided to the lessor. In addition, the leasee's incremental implicit rate of interest and financial position shall be considered.

(C) The test of reasonableness shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

(D) Absent clear justification to the contrary, material capital improvements to leased property that are necessary to maintain the asset in its ordinary state of usability at the commencement of the lease, shall be the responsibility of the lessor. Examples of said costs are roof or utility service replacement due to reasons beyond the prudent control of the lessee.

(E) Effective July 1, 1993, requests for prior approval of new leases and lease renewals must be submitted whenever possible at least 120 days prior to the last date for the exercise of the lease or lease renewal option. HUD leases with individual ICF-MR clients are not subject to this requirement.

(F) Failure to acquire prior approval of leases and lease renewals shall result in the disallowance of said cost from Medicaid reimbursement, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(2) The lease shall be considered an arm's-length transaction in accordance with Medicare Principles of Reimbursement as contained in the HCFA-15. Leases failing the HCFA-15 arm's-length transaction test shall be reimbursed at the leased asset's reasonable cost of depreciation, interest, if any, and other related expenses, including but not limited to reasonable maintenance costs, as determined by the Division of Medical Assistance. It is the responsibility of the provider to maintain auditable records to document these ownership costs to the Division of Medical Assistance or its designated contract auditors. Undocumented costs will be disallowed.

(3) The lease amount is comparable to similar leases for properties with similar functions in the same geographical area.

(4) The lease agreement between unrelated parties shall include the provision that the amount of rental to be paid by the lessee to the lessor shall not, in any event, exceed the amount approved by the Division of Medical Assistance.

(j) Depreciation shall be an allowable cost when based upon factors of historical costs and useful life. Depreciation shall be subject to the provisions of this Paragraph and Subparagraph (j)(1) of this Section. For the purpose of this Section:

(1) Unless an exception is made by the Division of Medical Assistance, the useful life shall be the higher of the reported useful life or that from the Estimated Useful Lives of Depreciable Hospital Assets (1988 edition). **A copy of the Useful Lives of Depreciable Hospital Assets can be obtained by writing to the American Hospital Association,840 Lake Shore Drive, Chicago, Illinois, 60611.** In certain instances, a useful life that is based upon historical experience as shown by documentary evidence and approved by the Division of Medical Assistance may be allowed. Should the provider desire a depreciation rate different from that based on the general rule in Subparagraph (j)(1) of this Section, then said provider shall make the request in writing to the Division of Medical Assistance. Upon review and analysis, the Division of Medical Assistance shall make a determination in writing as to the reasonableness of said request.

(2) The depreciation method used shall be the straight-line method.

(3) Unless an exception is granted by the Division of Medical Assistance, depreciated rates shall be applied uniformly and consistently in accordance with this State Plan and generally accepted accounting principles. Should the provider discover that depreciation has been improperly recorded in prior years, then the provider shall within 30 days report the error to the Division of Medical Assistance. The impact of the error on the provider's rate shall be fully considered by the Division of Medical Assistance and a rate adjustment may be made, with due cause shown. Failure to record depreciation properly shall result in disallowance for Medicaid reimbursement purposes, unless failure to comply with this provision was caused by reasons beyond the control of the provider.

(4) Depreciation paid to the provider by the Medicaid Program shall be prudently used by said provider to meet the financial requirements of providing adequate service to the ICF-MR clients.

(A) Payment to related parties for costs disallowed by this plan for Medicaid reimbursement may be considered imprudent use of depreciation reimbursement.

(B) Imprudent use of Medicaid reimbursement of depreciation may result in the provider being required by the Division of Medical Assistance to fund the depreciation through a qualified independent entity or disallowance of depreciation for Medicaid reimbursement.

(5) In order to substantiate depreciation expense for Medicaid reimbursement purposes, the property records shall include, at a minimum, all of the following, for assets purchased on or after July 1, 1993:

(A) The depreciation method used,

(B) A description of the asset,